ness in treating such a condition. Among the key factors in selecting from available media are economic and spatial considerations.

For many persons seeking help, a clinician's permission to use carefully structured learning programs which provide limited information and offer specific suggestions, may be sufficient to alleviate, and in some instances eliminate, the presenting complaint.

RONALD J. PION, MD

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Follow-Up of Molar Pregnancy

HYDATIDIFORM MOLE complicates about one in 1,500 pregnancies in the United States. Prediction of which 15 to 20 percent of these molar pregnancies will demonstrate malignant sequelae often cannot be based on histologic examination of the evacuated mole. For this reason it is of critical importance to follow *all* patients with serial chorionic gonadotrophin (HCG) assays, since this is a sensitive biologic marker of trophoblastic activity. In addition, periodic x-ray studies of the chest and pelvic examinations are important, since the lungs and vagina are the commonest sites of metastatic disease, and subinvolution of the uterus suggests persistent uterine disease.

There are several components to an acceptable follow-up program:

- An HCG assay done every one to two weeks using a sensitive serum radioimmunoassay until
  1. HCG is no longer detectable at sensitive levels for three consecutive determinations (patient has entered spontaneous remission). Follow with HCG assays every two to three months for one year.
  2. HCG plateaus are at an elevated level. Institute therapy.
  3. HCG rises significantly. Institute therapy.
  4. Metastases are detected. Institute therapy.
- Biweekly pelvic and physical examinations to rule out metastases and to note uterine/ovarian regression.
- Baseline chest x-ray studies for metastases; follow-up films if HCG does not steadily decline.
- Prompt institution of effective contraception, continued at least one year.

An essential aspect of proper follow-up is meticulous attention to the serial HCG titers.

WILLIAM E. LUCAS, MD

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Ultrasound in Obstetrics

THE ADVENT OF ULTRASOUND has been a major advance in fetal and maternal evaluation throughout pregnancy. It provides a safe and reliable method to obtain information that will be useful for the diagnosis and management of clinical problems.

The gestational sac can be visualized as early as the sixth week (counting from the last menstrual period), and its location is defined as intrauterine or extrauterine, thus diagnosing ectopic pregnancy. Two or more gestational sacs will indicate multiple pregnancy. The fetal head is well defined by 14 weeks and the measurement of the biparietal diameter will correlate with gestational age. This correlation can be improved by simultaneous measurements of the diameter of the fetal thorax. A biparietal diameter of 9.5 centimeters or more usually indicates a term fetus. This is useful in the clinical evaluation of patients with questionable dates, diabetes, erythroblastosis or hydramnios, or those scheduled for induction of labor or cesarean section.

Serial cephalometry may show accelerated growth suggestive of hydrocephaly, while slow growth provides a clue for intrauterine growth retardation. Failure to demonstrate a fetal head with repeated scans after the 14th week indicates anencephaly. An arrest of cephalic growth associated with loss of circular outline in both head and thorax, and failure to locate fetal heart beat with the ultrasonic Doppler, will diagnose fetal demise.

Placental localization is one of the most outstanding achievements of ultrasonic diagnosis. The location of the placenta by direct visualization and its relationship with the fetus and uterine

structures has obvious clinical significance in a situation like placenta previa or before amniocentesis. At the same time, structures, margins and surfaces can be evaluated with the gray scale technique for other types of placental pathology such as abruptio. Molar pregnancy can be diagnosed quite early since it produces a typical echo pattern.

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Ambulatory Surgical Gynecology

GYNECOLOGICAL SURGICAL PROCEDURES that are brief and low risk and for which postoperative care is simple (such as dilatation and curettage) may often be best done on a come-and-go basis in a surgical facility which has been especially designed for ambulatory patients. Such a facility may be developed in a physician's office, a clinic, a separate facility ("surgicenter") or a general hospital. It must be equipped to provide all the safeguards that are standard in a general hospital. The entire facility, its maintenance and its records, must be accessible for peer evaluation and review.

Whether general anesthesia or local anesthesia is used, the ambulatory surgical facility should provide adequately maintained monitoring and resuscitation equipment. Local infiltration or paracervical block anesthesia, possibly supplemented by intravenously administered diazepam (Valium®), is often satisfactory to both patient and physician. If general anesthesia is used, it should be professionally administered. Careful preoperative evaluation to insure low risk status and competent immediate recovery care must be provided. However, after the patient has recovered from general ansthesia, further postoperative care by loved ones in the familiar surroundings of home may be as safe and far more agreeable than the regimented professional routines normally provided by hospitals to inpatients.

Lesions of the vulvae, such as Bartholin cysts needing marsupialization, sebaceous cysts needing excision, suspicious skin or mucosal lesions needing biopsy, perineal stenoses needing reverse perineorrhaphy and even breast biopsies, may usually be managed satisfactorily under local anesthesia. Dilatation of the cervix, uterine curettage, difficult intrauterine device insertion or removal, cervical cauterization, superficial conization and menstrual extractions, may all be performed under paracervical block anesthesia using mepibacaine hydrocloride (Carbocaine®) and lidocaine. Laparoscopy and extensive cervical cold conizations on come-and-go patients are more commonly done under general (thiopental [Pentothal®]) anesthesia. Preoperative risk evaluation must always be done. Patients who are high in surgical risk due to advanced age, severe anemia or vascular diseases, should, of course, be admitted to a hospital for treatment.

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Lymphangiography and Cervical Cancer

THE IDEAL METHOD for the detection of lymph node metastases in patients with cervical cancer would be accurate, easy to carry out and easy to interpret, and would not require exploratory operation. Though lymphangiography does not meet all these requirements, it is better than any other available method. Negative lymphangiographic results are not of much value because (1) not all nodes in the pelvic and aortic areas are normally visualized and (2) metastases less than 3 mm in size are not seen as defects in the node. Nevertheless, when lymphangiograms give positive results (and are done by experts and evaluated using strict criteria), they are reliable. The finding of a lymph node filling defect not transversed by lymphatics is the most reliable criterion for identifying metastasis. Other findings such as lymphatic obstruction, collateral circulation or stasis may result from other causes and are not sufficiently reliable to be useful clinically.

Many centers employ lymphangiography as an orientation technique to be used for patients in whom routine surgical exploration with lymph node biopsy of lymphangiographic suspicious areas is to be done. Should biopsy specimens show the presence of metastatic carcinoma in aortic lymph nodes, treatment portals are enlarged to include